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The Stereotype of Organized Medicine

THE STEREOTYPE of organized medicine that seems to be widely held by many opinion leaders, and therefore by many others, should be of concern to medical associations, and no doubt it is. The stereotype is that doctors make too much money, that organized medicine is self-serving and that medical societies, no matter what their rhetoric in behalf of patients or the public, are first and foremost trade associations whose bottom line is protecting and defending the economic and professional self-interests of their physician members. Those who hold and act upon this stereotype include influential persons in government, in the communications media, among the public and probably within the medical profession itself if one thinks of the substantial number of physicians who have not yet chosen to become members of these professional associations or who have discontinued their memberships. On the other hand, public opinion surveys conducted by the American Medical Association and others do not appear to show much public support for this stereotype. Rather, organized medicine is held in relatively high esteem among the general public, and the percentage of the public expressing overall satisfaction with their last visit to a physician was a remarkable 89% in a survey done in 1983. But in no way should the stereotype be lightly dismissed. Legislators, health care policymakers, and leaders of some citizens' groups have spoken out and taken many actions based on their belief in this stereotype which they have accepted as valid.

But just how real is it? How well does the shoe actually fit? It is certainly true that organized medicine does seek to protect the turf of physicians in patient care, it does try to protect physicians' incomes and it does say that this is all done in the interests of good patient care which is surely in the interests of the patients who need this care. However, this is not just rhetoric. Most physicians believe this is true and that by and large what they do in the interests of themselves and their profession results in better care for patients. But organized medicine does other things too. It has a genuine concern with medical education and with the quality, cost and access to care. It is deeply concerned with quality of life for patients and with health and quality of life for all citizens. And it is beginning to find new ways to bring the experience and professional expertise of its members and their professional colleagues to bear on problems of health and health care. The Scientific Board of the California Medical Association and the DATTA project of the American Medical Association may be considered just forerunners of what can and no doubt will be done to bring these great resources of professional expertise and experience more effectively to bear in the patient and public, as well as the professional, interest.

But the stereotype of organized medicine remains, and whatever its validity, it is too often used, and too often unfairly used, against the profession. While it is true that physicians and the organized profession still enjoy substantial public confidence and trust, it is also true that when push comes to shove the real power does not lie with organized medicine. It lies with government, with the communications media, with voters and organizations of voters—that is, with society. It is easy to forget that physicians and the medical profession are given their training by society, and then given the privilege to serve its needs. Confrontation with society is not really an option for organized medicine although at times it has been tried. Rather, both physicians and organized medicine must look to a future of collaboration with patients and with society and put aside the authoritarian past. Just as doctors no longer order patients, the medical profession can no longer dictate to society, but they can and should bring their professional expertise to bear wherever decisions are made that pertain to health care. The current stereotype is something of an albatross around the neck of organized medicine and it will continue to be until the real goals of the medical profession are made more obvious to all.

There are many practical opportunities ahead for physicians and organized medicine to change this stereotype. Competition has already given rise to greater physician concern with a patient's personal convenience. Physicians and organized medicine are moving to fill the vacuum of patient advocacy that has been created by competition, third party and governmental interventions in patient care. The data bases that are coming into being to control costs will provide much needed information on the quality and effectiveness of care which physicians can turn to account to improve quality, costs and access in their own practices. Organized medicine can develop a new emphasis on documented practice performance of individual physicians who are their members. One is reminded that in former times membership in organized medicine was equated with being an "ethical physician" and considered a sign of competence and integrity for practice. Change will come slowly. It will be based upon good performance by physicians and organized medicine, in the genuine patient and public interest, which is understood and appreciated by influential persons in government, in the communications media and among the public.

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